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DDASaccident013

Humanitarian Demining Accident and Incident Database
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DDAS Accident Report

Accident details

Report date:	22/01/2004	**Accident number:**	13
Accident time:	10:57	**Accident Date:**	08/03/1995
Where it occurred:	MF No.1 Ta Ong West, Bentey Meanchey	**Country:**	Cambodia
Primary cause:	Field control inadequacy (?)	**Secondary cause:**	Victim inattention (?)
Class:	Victim inattention	**Date of main report:**	18/04/1995
ID original source:	KN	**Name of source:**	CMAC
Organisation:	[Name removed]		
Mine/device:	PMN-2 AP blast	**Ground condition:**	not recorded
Date record created:	12/01/2004	**Date last modified:**	12/01/2004
No of victims:	1	**No of documents:**	1

Map details

Longitude:		**Latitude:**	
Alt. coord. system:	GR: 806283	**Coordinates fixed by:**	
Map east:		**Map north:**	
Map scale:		**Map series:**	
Map edition:		**Map sheet:**	
Map name:			

Accident Notes

no independent investigation available (?)

victim ill (?)

Accident report

At the time of the accident the demining group operated in three-man teams with a two-man drill. In this one deminer used the detector and marked any signals while another looked for tripwires, cut undergrowth and excavated any detector readings. A third deminer was resting. The three rotated at fixed intervals.

An internal investigation report was prepared by the country MAC Investigating Officer and found on file in January 1999. Dated 18th April 1995, the following summarises its content.

The victim was a detector man for his platoon and was working in his lane when at 10:57 the site manager blew a whistle to signal the beginning of a break period. The victim stood up and turned to return to the rest area but suddenly fell. He landed with most of his body in an

uncleared area and detonated a PMN-2 with "his head". He was blown back into the cleared lane and died instantly.

The picture above shows the area around the Victim being checked with a detector.

The Platoon Commander ordered the area around the body to be swept with a detector and then went to investigate. The victim was lying face upwards with large injuries to the lower part of his face. He was still holding his detector handle.

The victim's partner and prodder man, said that the victim had told him that he hadn't had enough sleep the previous night because he had to care for his sick child. He also mentioned that the victim had gone to drink water three times that morning. He stated that the victim "did not bring his food to eat in the demining area ...had eaten some rice with his partner".

The Section Commander said that as they were getting off the truck that morning the victim said that he did not feel well and did not know whether to work or not. He decided to work because another deminer was already taking sick leave.

The victim's wife was interviewed on 19th April 1995. She confirmed that one of their children had been seriously ill, and that her husband had not slept well for several days. She had suggested that he asked for sick leave, but he had decided not to.

Conclusion

The investigators concluded that the victim had fainted because of dehydration and lack of sleep. The accident was therefore not due to a breach of SOPs but due to the victim's poor health.

Recommendations

The investigators recommended that the Site Manager, Platoon Commander and Section Commander were to make sure deminers had enough sleep (7-8 hours) and had taken enough water and food to the site. They said that deminers should be checked for their health each morning and not be allowed to work if there is any sign of illness. They also recommended that break times should be from 10:30 to 11:00, and 12:00 to 13:00.

Victim Report

Victim number:	24	**Name:**	**[Name removed]**
Age:	32	**Gender:**	Male
Status:	deminer	**Fit for work:**	DECEASED
Compensation:	US$4000	**Time to hospital:**	not recorded
Protection issued:	Safety spectacles	**Protection used:**	Safety spectacles

Summary of injuries:

INJURIES

severe Head

FATAL

COMMENT

No medical report was made available. Compensation of US$4000 was approved on 11th May 1995.

Analysis

The primary cause of the accident is listed as a "Field control inadequacy" because the victim was sick (and known to be by others in the group) and was still allowed to work. There appears to have been no pressure on him to work, but other absences made him feel obliged to do so.